VERMONT
AGENCY OF HUMAN SERVICES
DEPARTMENT OF DISABILITIES, AGING AND INDEPENDENT LIVING

Division of Licensing and Protection
103 South Main Street, Ladd Hall
Waterbury, VT 05671-2306
http://www.dail.vermont.gov
Voice/TTY (802) 871-3317
To Report Adult Abuse: (800) 564-1612
Fax (802) 871-3318

August 29, 2012

Mr. Willem Leenman, Administrator
47 Main Street
PO Box 38, 706 Main Street
Castleton, VT 05735-0038

Provider #: 0502

Dear Mr. Leenman:

Enclosed is a copy of your acceptable plans of correction for the survey and complaint investigation conducted on **July 6, 2012.** Please post this document in a prominent place in your facility.

We may follow up to verify that substantial compliance has been achieved and maintained. If we find that your facility has failed to achieve or maintain substantial compliance, remedies may be imposed.

Sincerely,

Pamela M. Cota, RN
Licensing Chief

PC:ne

Enclosure

Division of Licensing and Protection

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	0502	A. BUILDING _____ B. WING _____	C 07/06/2012

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
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T 001	INITIAL COMMENTS An unannounced complaint investigation was conducted on 07/05/12 - 07/06/12 to determine regulatory compliance with Vermont's Therapeutic Community Residence Regulations. The following are regulatory findings:	T 001	See attached Plans of Correction.	
T 002	IV.A.1 Resident Care and Supervision General The Director shall provide every resident with the personal care and supervision appropriate to his/her individual needs. This REQUIREMENT is not met as evidenced by: Based upon record review and staff interview, the Director failed to provide, for one applicable resident, supervision appropriate to his/her individual needs. (Resident #1) Evidence includes: 1. Per record review on 07/05/12 of the initial intake, family correspondence, physicians' recommendations and actual behaviors for Resident #1, who was admitted on 01/11/12, the home failed to provide close supervision that was assessed as being necessary prior to admission. Per a review of the Neuropsychological Evaluation Report dated 05/28/10 the physician stated that the resident "would need 24/7... consistent monitoring by both medical and rehabilitation/substance abuse professionals". An Evaluation Report for Guardianship dated 11/23/11, the physician stated "as a result of [Resident #1's] deficits in cognitive functioning as documented on standardized testing and demonstrated in daily actions to self care, making decisions regarding behavior in the community,	T 002	7/30/12 Willem Leenman WILLEMA LEENMAN, MHSA, DIRECTOR	

Division of Licensing and Protection

TITLE (X6) DATE

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

PMC

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T 002	Continued From page 1 and maintaining control of life threatening medical conditions, [resident] requires full time supervision and treatment resources". Per an admission application letter from the family to the Director, it states that the Resident would "need close monitoring/supervision and is not safe out in the community by himself/herself". Per the staff G&O sheet (Goals and Objectives) dated 02/12/12 states "improve physical health, eat the right things, abstain from alcohol, improve vocational skills & become an honest and trustworthy person." With the objectives of: did resident pay attention to his/her diet, how many times did resident monitor the glucose level, did resident maintain sobriety, was resident able to work in the work program and stay on task, did resident put away tools that he/she used and cleaned up after he/she was finished with the project by staff observation, was resident honest took nothing did what he/she said he/she would do, daily 1/2 hour exercise. There is no evidence of a treatment plan or interventions for close supervision. Per an incident report dated 02/09/12 and the monthly report for January/February 2012, Resident #1 "was found intoxicated, stole money and took medications from another resident". Staff were to "carefully monitor the resident and to be on the grounds until a meeting", 2 days later. Per the monthly report of March 2012 the resident was again intoxicated and "returned to the residence by the local police". In the monthly report of April 2012 the Director wrote " if [resident] continues to work against us, our recommendation is a place with limited freedom and around the clock nursing". The monthly report of May 24, 2012 states "the bottom line is that [resident] requires constant supervision....".	T 002		

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T 002	Continued From page 2 An addendum dated June 6, 2012 states "May 26 [resident] left the house without staff permission ...got arrested for DWI, driving without a license and traffic violations...father is angry with us that [resident] was without supervision...father is looking at other programs...". Per a staff note of 06/15/12 "at this time I was not sure if [resident] was allowed to run up to the store of not...". There is no evidence by documentation that a treatment plan was revised following the above incidents or how staff were to closely monitor the resident. Per interview on 07/05/12 at 11:30 AM the Director stated "we're not a locked facility" and confirmed that although monitored for the general goals, the resident. was not closely supervised.	T 002		
T 003	IV.A.2 Resident Care and Supervision Medication The Director shall assure that all medications and drugs are: a. used only as prescribed by the resident's physician b. properly labeled and kept in a locked cabinet at all times or, when a program of self-medication is in effect, otherwise safely secured. This REQUIREMENT is not met as evidenced by: Based on record review and interview, the Director failed to assure that all medications are securely locked at all times. Findings include: 1. Per record review on 07/05/12, an incident report dated 02/10/12 states that staff were informed that Resident #1 drank alcohol and that	T 003		

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T 003	Continued From page 3 medications (3 Ritalin and 1 mirtazapine) were missing from Resident #2. "The 3 Ritalin were found in a decomposed state in [Resident #1]'s room along with a watch which [Resident#1] said [s/he] thought [s/he] had taken from [Resident #2's] room". Also, per a self-reported incident to the Division of Licensing and Protection dated 6/18/12 "over the weekend [06/16 & 06/17] at 00:45 [Resident #1] took a fire extinguisher and sprayed another resident while in bed and the dust set off the smoke detector....the facility also discovered that [Resident #1] stole another resident's medication when the building was evacuated. [Resident #1] stole [Resident #2's] Seroquel and heart medication which was was located in the bedside drawer. Normally the door is locked, but it needed to remain unlocked when the building was evacuated". Per interview on 07/05/12 at 1:30 PM the Director stated that the medications for residents who are able to self administer [presently 2 out of 10] "keep the doors locked when they are not in their rooms, but during a fire evacuation the doors are kept open so the fire department can check to see if everyone is out." The Director was unable to state with certainty that the medications for these residents are always safe guarded and confirmed that " the medications will have to be better secured".	T 003		
T 088	VI.2.B.2.c. Common Model Program Standards Treatment Components Process--Identification of Problems and Areas of Successful Life Function The identified problems and achievements shall be used as a basis for the development of a	T 088		

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T 088	Continued From page 4 treatment plan and goals for each resident. This STANDARD is not met as evidenced by: Based on record review and confirmed by interview, the facility failed to develop a treatment plan to address an identified problem for 1 applicable resident (Resident #1). Findings include: 1. Per record review on 07/05/12 at 1:30 PM, Resident #1's treatment plan did not include interventions to address an identified problem of requiring close supervision. Per two physician evaluations and family correspondence during the initial intake, Resident #1 would need close monitoring/supervision and would not be not safe out in the community by himself/herself. In addition, there was no information as to the resident's achievements. Per interview at 3:45 PM, the Director confirmed that there was not a written treatment plan to reflect attentive steps or goals for this identified problem. Also see T- 0002	T 088		
T 089	VI.2.B.3.a. Common Model Program Standards Treatment Components Process-- Treatment plan The treatment plan shall reflect steps to be taken to solve identified problems, either by direct service at the residence or indirectly by referral to a community resource. This STANDARD is not met as evidenced by: Based on record review and interview, the residence did not develop a comprehensive	T 089		

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T 089	Continued From page 5 treatment plan for 1 applicable resident (Resident #1) that identified specific steps taken by staff to assist the resident. Findings include: 1. Per record review on 07/05/12, Resident #1 who was admitted on 01/11/12, had an identified problem area of alcohol abuse and being unsafe in the community. The G&O sheet (staff record keeping of goals and objectives) states "did resident abstain from alcohol; did resident maintain sobriety". However, there are no specific staff interventions that might be employed to meet the residents' need to maintain sobriety and supervision in the community. In addition, a letter dated 03/09/12 to an out of state attorney states,"weekly individual alcohol and drug counseling ....and also part of weekly group therapy sessions," however, this is not addressed in the treatment plan. Per review of the incident reports and monthly reports for February 2012 and March 2012, noted Resident #1 was 'intoxicated, under the influence of alcohol' and 'again drank alcohol and was returned to 47 Main by local police', respectively. On 05/25/12 the resident left the house, with staff not knowing where the resident was for greater than 9 hours, before police arrested the resident for DWI. Per interview on 07/05/12 at 3:45 PM AM the Director stated that when the residents are admitted, there are program expectations not to drink alcohol and to let staff know the whereabouts. The Director confirmed at this time that a treatment plan, which would identify all necessary care areas and specific staff interventions that might be employed to meet the resident's needs were not completed .	T 089		

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T 089	Continued From page 6 Also see T-0002 & T-0088	T 089		
T 090	VI.2.B.3.b. Common Model Program Standards Treatment Components Process-- Treatment plan The treatment plan shall contain clear and concise statements of at least the short-term goals the resident will be attempting to achieve, along with a realistic time schedule for their fulfillment or reassessment. This STANDARD is not met as evidenced by: Based on record review and staff interview, the residence failed to develop a treatment plan for 1 applicable resident at the residence. (Resident #1) Findings include: 1. Per record review on 07/05/12 for Resident #1, there was no treatment plan that identified clear and concise short-term goals nor time frames for completion. Although there was a ' G&O sheet', which is a monitoring tool used by staff, it did not identify specific goals, outcomes and steps needed for the treatment plan . Per interview on 07/05/12 at 3:45 PM the Director confirmed there was no treatment plan that contained concise statements of at least the short-term goals, realistic time schedule or reassessment. Also see T-0002, T0088 & T-0089	T 090		
T 102	VI.2.B.6.b. Common Model Program Standards Treatment Components Process--Resident Records Resident records shall include the following: 1. intake assessment summary	T 102		

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T 102	Continued From page 7 2. identification of problems and areas of successful life function 3. data from other agencies 4. treatment plans and goals 5. regular progress notes 6. supervisory and review conclusions 7. aftercare plan and discharge summary 8. appropriate medical information 9. client information release form This STANDARD is not met as evidenced by: Based on record review and interview, the Residence failed to ensure that all treatment components are included in the record of 1 applicable resident. (Resident #1) Findings include: 1. Per review on 07/05/12, Resident #1's record (admitted 01/11/12) was incomplete. During record review the resident's record (consisting of 4 binders) had a consent to treat form, History and Physical, physician notes, recent hospital visit notes, and a medication list. There was no identification of problems and areas of successful life function, treatment plans, client information release form or aftercare plan/discharge summary. Per interview at 3:45 PM the Director confirmed that the resident's record was incomplete.	T 102		
T 106	VI.2.B.8.c. Common Model Program Standards Treatment Components Process--Discharge and Aftercare A summary of the resident's stay at the facility shall be added to the resident record within one week of his/her leaving. This shall include reason for leaving, areas in which progress, no progress or regression was observed, and medication at	T 106		

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T 106	Continued From page 8 the time of leaving. This STANDARD is not met as evidenced by: Based on record review and interview, there is no summary note after Resident #1's discharge. Findings include: 1. Per record review on 07/05/12 at 11:30 AM, approximately 3 weeks after the resident was discharged on 06/15/12, there is no summary of Resident #1's stay, reason for leaving , medications or areas of progress or regression in the chart. Per interview with the Director later that day s/he stated that the discharge summary is "still in draft form" and confirmed there is no summary in the resident's chart.	T 106		

FortySeven Main Street, Inc.
Castleton, Vermont 05735-0038

General and specific comments in response to regulatory findings.

T 002 IV.A.1. Resident care and supervision.

The Neuropsychological Evaluation Report dated 5/28/10 which states the resident "would need 24/7...consistent monitoring by both medical and rehabilitation/substance abuse professionals". The Evaluation Report for Guardianship dated 11/23/11also states that the resident "requires fulltime supervision and treatment resources". Also: "need close monitoring/supervision and is not safe out in the community by himself/herself/". While neither of these reports is to be ignored, both of these reports were written in support of the petition for guardianship and are, therefore, biased in favor of the more restrictive interpretation of the situation. Our duty is not to ignore previous evaluations but use these to obtain a balanced view of past behaviors, past treatment modalities, current assessment and subsequent treatment and reasonable expectations for the future. We cannot be bound by previous recommendations, especially if they are possibly dated (5/10), but have a duty to have our psychiatrist, therapist, case managers and other professional support, weigh all evidence, including past records and evaluations, assessing current behaviors, to formulate a responsible treatment plan.

Because of the recommendation that [Resident 1] "is not safe out in the community by himself", [Resident 1] was placed in residential care. The report does not recommend that [Resident 1] be placed in a lock down facility.

From FortySeven Main Street, Inc's Intake Report dated 1/17/12. "[Resident 1] has been scratching his chin which has a sore on it. Per [Resident 1]'s father, any suggestion that [Resident 1] should not do this will only make matters worse. From our observations "[Resident 1] is easy to please but also easily hurt. He is trying hard to fit in and do the right thing." [Resident 1]'s paperwork strongly suggests that he requires a strict regiment of night time sleep/daytime awake, regular meal times, supervision regarding his health issues, encouragement and a safe environment in which to grow up."

Our consulting psychiatrist, Otto M. Marx, MD, DLFAPA, intake note (1/20/12) on Resident 1 states: "1. Establish therapeutic relationship." Impression: "Lifelong MH pt who wants to do his own thing, amenable to suggestions."

Our program philosophy is that we believe that any resident can grow, mature, learn, and grow in self confidence given the right support and structure. An essential ingredient is that the resident must have a sense that this is possible. A resident must have a sense that he has some control over his situation.

Thus, Dr. Marx's note from 1/20/12 continues:
2. Disc. of anxiety and its different experiences.
3. Ref. to Dr. Andrew Weil re breathing exercises.
4. Did some breathing exercises [with] pt. + ref to Egoscue book.
5. Disc. smoking + ? of what could replace cigs.
6. Disc skin care + ways of avoiding further scratching.

Additionally, Dr. Marx wrote: "probably of better intelligence than indicated by past history." (1/20/12)

All of these goals suggest that Dr. Marx believed that Resident 1 has a measure of control over his behavior and that he is not locked into his past behaviors.

Similarly, our own goals suggest the same: "improve physical health, eat the right things, abstain from alcohol, improve vocational skills [and] become an honest and trustworthy person". With the objectives of: did [Resident 1] pay attention to his diet, how many times did [Resident 1] monitor his glucose level, did resident maintain sobriety, was resident able to work in the work program and stay on task, did resident put away tools that he used and cleaned up after he was finished with the project by staff observation. Was resident honest, took nothing, did what he said he would do, daily ½ hour exercise.

Licensing and Protection alleges there is no evidence of a treatment plan or interventions for close monitoring. I disagree and suggest that none of these goals or objectives could be assessed without close monitoring. Our records prove that we have daily entries monitoring current behavior, and level of accomplishment/failure to do so.

FortySeven Main Street, Inc. holds a meeting for residents every weekday morning and afternoon. At this time, a resident would chose, or occasionally be assigned, to be on a particular crew under supervision of a FortySeven Main Street, Inc. staff member. [Resident 1] was always part of a crew, most often led by myself. On the rare occasions that he did not feel well and could not participate in a crew, he would be closely monitored in accordance with our standard policy regarding residents who are ill. On weekends and evenings, all residents are again closely monitored and are expected to be on grounds unless a different arrangement has been made with staff in charge.

Additionally, [Resident 1's] health, psychiatric, and substance abuse concerns were coordinated by FortySeven Main Street, Inc. and addressed by the following:

Otto M.Marx, MD, DLFAPA, consulting psychiatrist.

Carolyn Prescott, M.Ed, L.A.D.C. psychotherapist, Specializing in Substance Abuse Treatment. [Resident 1] attended weekly group and had individual therapy until he decided to quit.

Bradley A. Berryhill, MD, Castleton Family Health, who agreed to take on [Resident 1]'s physical heath issues at my request although Dr. Berryhill was not taking any new patients.

James Jordan, MD, Castleton Health Associates who saw Resident in addition to Dr. Berryhill on two occasions.

Physician Assistant, Castleton Family Health 1/17/12 for cold symptoms.

Castleton Family Health, lab work 2/27/12, 5/10/12

Rutland Region Diabetes and Endocrinology Clinic where Resident 1 was seen by Carolyn Goodwin, FNP-BC and Donna Hunt, RD, CDE.

Philip Lapp, MD, endocrinologist. Appointment scheduled for 6/27/12.

Also: Dorina Kramer, DDS, Castleton, for dental care.

Also: Christine Skoglund, MS, Co-Director and Program Coordinator at FortySeven Main Street, Inc. who took a special interest in Resident 1's dietary needs and diabetes. Christine Skoglund work with Resident 1 on his dietary shopping needs, prepared meals appropriate for his dietary restrictions, taught our staff about gluten free meals and food preparation.

Additionally: Rutland Regional Medical Center where Resident 1 was seen in the ER 3 times one week, specifically 4/16/12, again on 4/19/12, and admitted. Also on 4/21/12 and admitted.

I my opinion, the above team of professionals helped to provide the close monitoring and supervision that Resident 1's complex issues demanded.

On 3/2/12, our consultant psychiatrist Dr. Marx wrote in his note: Impression: "may be able to work things out here. Cont to set limits, yet be aware of pt's hypersensitivity." Dr. Marx goes on: Plan: "in meantime emphasize pt's self control…"

We continued to provide [Resident 1] with daily structure, supervision and encouragement.

[redacted]

It is my professional opinion that the above degree of supervision was adequate to address supervision of personal safety, medical issues, psychiatric and substance abuse issues.

As an example that we responded adequately to [Resident 1's] need. [Resident 1] was hospitalized went to the ER three times, and was twice admitted to the hospital, in a one week period in response to severe stomach pain.

[redacted]

* Prior page removed due to privacy issues.

of close supervision, and in response to our alleged failure to provide a treatment plan.

Plan of Correction:
1. our supervising RN will review all residents' goals and objectives to ensure that they comply with TCR regulations.
2. We will review our admission criteria to ensure that we are able to provide the level of care each resident requires.
3. Implement resident assessment to be completed within 14 days of admission and then on a yearly basis. T002 POC accepted as circled 8/27/12 PMcotaRN

T 003 Medication.

As stated in the report, all medications were not locked up as required by TCR regulations. On two occasions, [Resident 1] stole medication from another resident.

Plan of correction:

We have installed locked cabinets in all rooms where residents administer their own medications or OTC medications. The locked cabinets are screwed to the wall or shelf. The shelf is secured to the wall or bookcase. Residents have a key to the cabinet and a spare key is kept in the staff room. We will make sure that in the future, if a resident is in charge of his own medication, there will be a separate locked secure storage for these medications.

Locked storage areas were installed on July 8, 2012.

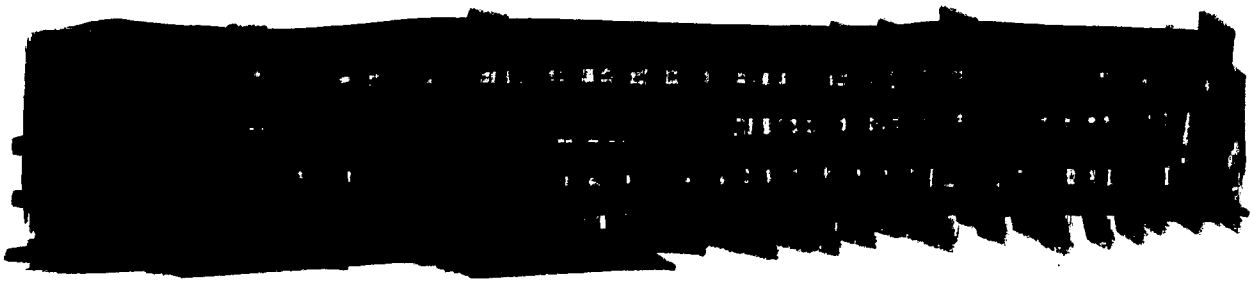
T003 POC accepted 8/27/12 PMcotaRN

T 088 VI. 2 B 2 c Common Model Program Standards

Lack of Intervention. Record does not include interventions to address problems.

I believe, we were consistently mindful to maintain a therapeutic relationship with [Resident 1], as recommended by our consulting psychiatrist, Dr. Marx. Similarly, [Resident 1's] father and guardian had informed us that there were periods in his son's life when he had done well. According to the guardian, these were times when [Resident 1] had a special relationship, such as with a teacher, who saw not only the problems but [Resident 1's] potential. Our hope was to provide such a nurturing environment for [Resident 1].

The strength of our program is that we respond to each resident and each situation differently. Rather than dictating that there be a predictable reaction on our part to each event, we opt for the therapeutic approach, which in our opinion, requires that we RESPOND rather than REACT. Thus, rather than having an established protocol and following protocol, we ask in each situation does this require kindness and understanding, or does the situation require firmness and restrictions? What is the best approach to maintain the therapeutic relationship and address the issues at hand?



We did respond to situations. On 2/10/12, Friday evening, [Resident 1] had drunk alcohol and stolen money and medications from [Resident 2]. Staff on duty correctly notified both the Director and Program Coordinator. They correctly wrote an event report. They correctly wrote a plan of action: "We continued to carefully monitor [Resident 1] all day" This refers to Saturday, 2/11/12.

I followed up with written instructions:
"1. [Resident 1] on grounds until we have had a mtg (likely Monday)
2. Hold all [Resident 1]'s allowance—for his own safety."

Additionally: "at my request, Shirley {staff} spoke w/ Carolyn Prescott, addiction counselor, about this. Carolyn will see [Resident 1] Monday 2 pm." The above is, of course, documented in [Resident 1's] record.

Plan of Correction:

Review of all resident records.

1. **Meet with consulting therapist, consulting Registered Nurse, consulting psychiatrist, all case managers, Program Coordinator and Director to formulate plans of intervention for all residents.**

2. Plan of Intervention to be part of permanent resident record.

T088 POC accepted as circled 8/27/12 PMcotaRN

T 089 Common model program standards

Lic. and Protection states: "no comprehensive treatment plan". I believe these concerns are addressed under Resident Care and Supervision. See above.

Plan of Correction:

Our supervising Registered Nurse will review all residents' records to ensure that TCR Regulations are met in regard to treatment plans.

T089 POC accepted 8/27/12 pmcotaRN

T 090. Common Model Program Standards

The record shall contain clear and concise statements of at least the short term goals.....with a realistic time schedule.

During the complaint investigation by Licensing and Protection on July 6, 2012, we had a discussion regarding our stated goals, specifically our written goal for [Resident 1] to "become an honest and trustworthy person".

The investigator stated that this would be an impossible goal to measure. I maintained at that point that everyone knows when he/she is dealing with a person who is honest, has integrity, or is essentially a liar.

The aim of our program is similar to the aim of our educational system and the hope for most families: namely, to produce citizens who contribute to society, who can make sound decisions, who can support our society through paying taxes and through their citizenship and who can become the next generation to be in charge. Such goals are difficult to measure. Nevertheless, many of us intuitively sense, when we get to

know someone, whether this person meets the standards of solid citizenship.

Had our expectation for [Resident 1] been lower and our goal had been to: brush teeth twice daily and floss every night. This would have made the goal relatively easy to measure but would not address the underlying issue that [Resident 1] has a long history of lying, stealing and addiction and consequently serious issues with the legal system.

We promote our program as being "a community". Numerous times we are told by people who visit our program, or who see our website, that they are attracted to our philosophy and our approach.

Former Surgeon General, C. Everett Koop, MD, who visited our program in January 2008 said the following: "Programs like FortySeven Main are like an oasis in an otherwise mostly barren field of mental health."

Did [Resident 1's] guardian believe our approach was correct for his son?

I believe we have a professional and moral obligation to address those issues most pertinent and urgent. We cannot, out of convenience, or because some goals do not fit in a neat time line, bypass what is most essential in favor of goals more easily measurable and within certain established timeframes.

Plan of Correction:

1. Work with consulting Registered Nurse, consulting therapist, consulting psychiatrist and case manager to develop goals that meet TCR regulations.

2. Review all current residents' charts and make certain goals are clearly stated within the allotted time frame.

TD90 POC accepted as circled 8/27/12 PMcLaren

T 102 VI. 2. B. 6. B Common Model Program Standards

Licensing and Protection claims that we were errand in having certain documentation missing from the record of [Resident 1]. I would like to address the absence of an aftercare plan which Licensing and Protection correctly noted is not part of [Resident 1's] record.

I respectfully disagree with Licensing and Protection that we failed to meet TCR Regulation regarding a discharge plan and regarding an aftercare plan.

The fact is [Resident 1] left our facility after being arrested by the police and was immediate placed in jail. This was never part of our plan. We

could not have foreseen this. At this point, with [Resident 1] housed at the Rutland Region Correctional Center, we had little control over any aftercare follow up.

However, I did go to Rutland Region Correctional Center and spoke with one of the officers. I wanted to make certain that RRCC was aware of [Resident 1's] medical needs. I was informed that their medical team would carefully evaluate [Resident 1]. I contacted the guardian by phone and informed him of this. RRCC contacted me the next day by phone and requested that I bring them certain medical supplies. I obtained permission from [Resident 1's] father and brought the requested supplies to RRCC.

I also contacted the guardian via email on Monday, June 18, 2012 at 3:59 pm informing him of the court proceedings and of two important medical appointments that were coming up.

None of the above was part of a treatment plan and there were, therefore, no records showing that this would be the aftercare plan. But in my mind it speaks to the constantly evolving events and to our attempts to continue as best we could while the situation became unmanageable.

Licensing and Protection writes: "During record review the resident's record (consisting of 4 binders).....".
[Resident 1] has a thick record consisting of more than 100 pages. We kept immaculate records of all his medical appointments, there are records of all event reports, there are daily log entries, there is daily tracking of goals and objectives, there are records on progress meetings, psychiatrist's notes, notes of group therapy, background information, correspondence with probation in NJ, correspondence with [Resident 1's] guardian, complete medication history, dietary information, schedules for insulin pump changes, summaries of all medical appointments, and notes of restrictions placed on [Resident 1].

I do not deny that I was late writing a discharge summary. I went to court on Monday, June 18 for [Resident 1's] hearing. It became official on that date that [Resident 1] was no longer one of our residents but would remain at the Correctional Center. I wrote the discharge summary on June 27, 2012. However, it remained in draft format and did not become part of the record in the time frame required.

Plan of Correction:

1. All required paperwork will be due by the due date.

2. Our Program Coordinator, together with our Consulting Registered Nurse, will review all residents' records regularly to ensure all TCR Regulations are adhered to.

3. Residents' charts will be reviewed to ensure that an appropriate discharge plan is in place.

4. Residents' charts will be reviewed to ensure an appropriate aftercare plan is in place.

T102 POC accepted as circled 8/27/12 Pmcotwpn

Summary:

I understand the TCR regulations and understand where we could do better documenting Treatment Plans, Measurable Goals, Interventions, Discharge and aftercare plans. We will review all residents' records with the appropriate staff or consulting staff, to ensure that all records are in compliance with TCR regulations. We will then review at regular intervals to ensure we remain in compliance.

I expect that this process will start on July 30, 2012, and be finished no later than November 1, 2012.

Willem Leenman, MHSA, Director, July 30, 2012